COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

OLDER ADULTS (AGES 60+)
FULL SERVICE PARTNERSHIP
AUTHORIZATION FORM

CLIENT INFORMATION

***Insufficient details may delay referral process**

DMH IBHIS#: _____

DATE: _____ **SSN:** _____

LAST NAME: _____ **FIRST NAME:** _____ **PREFERRED LANGUAGE:** _____

DOB: _____ **AGE:** _____ **RACE/ ETHNICITY:** _____ **GENDER:** ☐ **M** ☐ **F** ☐ **OTHER**

CONTACT ADDRESS: _____ **CITY:** _____ **ZIP CODE:** _____

PHONE: _____ **CURRENT LIVING SITUATION:** _____

INSURANCE: ☐ **MEDI-CAL** ☐ **MEDICARE** ☐ **NONE** ☐ **PRIVATE:** _____

BENEFITS: ☐ **GR RECIPIENT** ☐ **V.A.** ☐ **SSI** ☐ **SSDI** ☐ **OTHER INCOME:**

☐ **CLIENT SERVED IN THE MILITARY** **CONSERVATOR?** ☐ **YES** ☐ **NO** **NAME:** _____

PHONE: (____) _____

PRIMARY CONTACT: _____ **PHONE:** (____) _____

RELATIONSHIP: _____ **PREFERRED LANGUAGE:** _____

REFERRAL SOURCE

Agency: _____ Provider # (if applicable): _____ Service Area: _____

Contact Person: _____ Phone: _____ E-mail: _____

Is Individual currently receiving mental health services from your agency? ☐ YES ☐ NO

Other Agency Involvement: ☐ Probation ☐ APS ☐ DMH ☐ Regional Center

If Individual was referred to any other programs, please identify: _____

_____

_____

FSP Agency Representative: _____

☐ Client is aware that an FSP referral has been made on his/her behalf.

LEVEL OF SERVICE

Individual's Name: _____

DMH IBHIS#: _____

Check ONE ONLY:

- ☐ Unserved (Not receiving mental health services)
  - ☐ History of mental health services, but none currently* ☐ No prior mental health services
- ☐ Underserved (Receiving some MH services, though insufficient to achieve desired outcomes)*
  - ☐ Recovery, Resilience & Reintegration Services ☐ PEI ☐ Other: _____
- ☐ Inappropriately served (receiving some MH services, though inappropriate to achieve desired outcomes because of cultural, ethnic, linguistic, physical, or other needs specific to the client)*

*If client has received community-based mental health services within the last 6 months, (1) identify the program(s); (2) indicate the type and frequency of services; and (3) explain why the services are insufficient/inappropriate to achieve desired outcomes:

_____

_____

_____

_____

_____

_____

DIAGNOSTIC CONSIDERATIONS

DSM-5/ICD-10 Code: _____

Check All that Apply to Individual:

- ☐ Aggressive Ideation
- ☐ Aggressive Acts (by history or current)
- ☐ Aggressive Threats (by history or current)
- ☐ Fire Setting Ideation or Acts
- ☐ Inappropriate Sexual Ideation
- ☐ Other _____
- ☐ Inappropriate Sexual Acts
- ☐ Psychiatric Hospitalizations (Indicate dates below)
- ☐ Suicidal Ideation/Attempts
- ☐ Symptoms of Psychosis
- ☐ Tarasoff Notifications (past or current)

Provide Detail for Any Checked Items:

_____

_____

_____

_____

_____

All DMH entities (directly-operated and contracted) must submit the Referral/Authorization Form via the Service Request Tracking System (SRTS). For Non-DMH entities, please fax the completed Referral/Authorization Form to the Impact Unit for your Service Area:

SA 1: Angela Coleman	(661) 537-2937	SA 5: Samantha Howard	(310) 313-0813	SA 8: Trisha Deeter	(562) 290-1230
SA 2: Darrell Scholte	(818) 347-8736	SA 6: Dawnette Anderson	(310) 223-0914	SA 8: Jenny Nguyen	((562) 290-1230
SA 3: Eugene Marquez	(626) 331-0121	SA 6: Perla Cabrera	(310) 223-0914		
SA 4: Phyllis Moore Hayes	(213) 680-3225	SA 7: Alicia Ibarra	(213) 384-0729		

FOCAL POPULATION

Individual's Name: _____

DMH IBHIS#: _____

Check either A. or B. **Please complete to the best of your knowledge*

If the client meets the focal population for section A. and/or B., the referral requires authorization.

A. ☐ **FOCAL POPULATION REASON(S)**

B. ☐ **AT-RISK REASON(S)**

A. CHECK APPROPRIATE FOCAL POPULATION REASON(S) FOR REFERRAL:

	# Days during last 12 months
☐ Public Guardian	_____
☐ Homeless ☐ [1]Chronically Homeless (HUD Standards)	_____
☐ Incarceration	_____
☐ Hospitalization	_____

☐ At imminent risk of homelessness (e.g. at risk of eviction due to code violations)

☐ Risk of going to jail (e.g. multiple interactions with law enforcement over 6 months of more)

☐ Imminent risk for placement in a Skilled Nursing Facility (SNF) or Nursing Home

☐ Being released from SNF/ Nursing Home Facility: _____

☐ Presence of a Co-occurring disorder:

☐ Substance Abuse ☐ Developmental Disorder ☐ Medical Disorder ☐ Cognitive Disorder

☐ Client has a recurrent history or is at risk of abuse or self-neglect who are typically isolated (e.g. APS- referred clients)

☐ Serious risk of suicide (not imminent)

Provide Detail for Any Checked Items:

_____

_____

_____

_____

B. CHECK APPROPRIATE AT-RISK REASON(S) FOR REFERRAL:

☐ At risk of out of home placement (Fall risk due to chronic health conditions and numerous medications, limited or no social and/or family support, etc.)

☐ At risk of becoming involved with the criminal justice system (Prior legal/incarceration history, Little or no family or social support, inadequate or no housing, etc.)

☐ At risk of being psychiatrically hospitalized (Suicidal ideation or attempts, Failure to coordinate and take both health and psychotropic medications as prescribed, limited or no connection to non-emergency community services, etc.)

Provide additional details

_____

_____

_____

_____

[1]Chronic Homeless HUD: A person sleeping in a place not meant for human habitation or emergency shelter with a disabling condition who has been continuously homeless for a year or more and/or an individual who has 4 episodes of homelessness in the past three years.